Bentleyville Chiropractic Center
104 Johnston Road – Bentleyville, Pa 15314
Dr. Brian S. Haschets

About You

Last_____

First_____ **M.I.**_____

What do you prefer to be called?_____

Gender _____

Date of Birth_____ **Age**_____

Address_____

City_____ **State**____ **Zip**_____

Phone # _____ ***Is this a cell or landline?*** _____

May we text you appt reminders? Y / N

Marital Status: Single, Married

Student Status: None, full time, part time

Emergency Contact_____ **Emergency #**_____

Who referred you to our office? _____

Or How did you hear about our office? _____

I acknowledge that this information is true, accurate and valid and I will not hold Bentleyville Chiropractic Center responsible for any misinformation given on this or any other form I sign.

Signed_____ **Date**_____

PLEASE READ CAREFULLY AND SIGN BELOW

MY RESPONSIBILITY

I acknowledge that I am ultimately responsible for payment of all care, evaluations, supplie and services provided to me by Dr. Brian S. Haschets/Bentleyville Chiropractic Center. I understand that if I have insurance, the insurance may pay all, some, or none of my bills an that I am responsible for the balance.

- I understand that all insurances have different allowances for chiropractic care.
- I understand that my insurance may have a deductible, co-insurance, or co-payment and that I will pay this amount as I am informed of it.
- Bentleyville Chiropractic Center will attempt to verify all benefit allowances prior to initiation of any care. I will not hold them responsible for misinformation given to them by my insurance company.
- I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that Bentleyville Chiropractic Center will prepare any necessary forms to assist in making collections from my insurance carrier and that an amount authorized to be paid directly to this office will be credited to my account.
- I authorize this office to release my diagnosis to my insurance company to receive payment and that this office may be using Electronic Billing via phone modem to receive it.

Print Name _____

Signature _____

Date _____

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Reason For Your Visit

Your name_____

List your complaints in order of severity: (include right, left, bilateral) _____

_____

When did this start_____

What caused this_____

What percentage of the day is the pain present: 0-25 25-50 50-75 75-100

When are the symptoms the worst: Morning Daytime Evening Sleep

Circle the number which best describes your pain RIGHT NOW for each complaint

0 1 2 3 4 5 6 7 8 9 10

***** 0 = no pain** **10 = I should be in the hospital *****

What makes your pain worse? Activity Bending Arising Standing Sitting Walking Coughing Lights/Noises _____

What relieves your pain? Nothing at all Ice Heat Rest Motion Laying Stretches Medications_____

Describe your pain: Ache Burn Dull Sharp Stabbing Tight/Spasm Stiff Weak Numb Pins and Needles

Does your pain radiate: Arms/Hands Legs/Feet Head/Face No

Have you ever had this before? Yes / No If yes, what helped?_____

Have you seen your MD for this problem? Yes / No **Were tests ordered?**_____

Is there any reason that you should not be adjusted in this office? Yes No

Any other information you would like to offer_____

Signed_____ **Date**_____

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Medical History

Last Name: _____ **First**_____

Family Dr:_____ **Last seen**_____

Surgeries and when performed_____

_____

Medications: _____

_____

Allergies:_____

Family History: Mother: Living Deceased Deseases_____

Father: Living Deceased Diseases_____

Work History: Type: Desk/Sedintary Light work Medium work Heavy Work

Years employed_____ Work_____ hrs per week

Personal History **Smoker:** Y N How long_____ How many per day_____

Alcohol: None Social Heavy **Coffee:** None Few Alot

Exercise: Never Light Heavy **Type**_____

Diet: Poor Decent Very Healthy

Do you have any metal implants (pacemakers, defibrilators, bullets)_____

Previous Chiropractic Experience: _____

I acknowledge that the above information is complete and accurate:

Signed_____ Date_____

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Review of Symptoms

Do you currently have any of the following sympoms?

Name_____

	YES	NO
Constitutional:		
A. Recent weight change?	☐	☐
B. Weakness, fatigue or chills?	☐	☐
Eyes:		
A. Difficulty seeing?	☐	☐
B. Contact Lenses?	☐	☐
C. Temporary loss of vision?	☐	☐
Ears, Nose, Throat:		
A. Dentures	☐	☐
B. Problems with hearing?	☐	☐
C. Hoarseness, sore throat, trouble swallowing?	☐	☐
Cardiovascular:		
A. Chest pain (heart pain, angina)?	☐	☐
B. Known heart rhythm problems?	☐	☐
C. *Leaky heart valves?*	☐	☐
D. Problems with circulation?	☐	☐
E. High or low blood pressure?	☐	☐
Respiratory:		
A. Chronic cough?	☐	☐
B. Shortness of breath with exertion?	☐	☐
C. Wheezing or asthma symptoms?	☐	☐
GI:		
A. *Constipation?*	☐	☐
B. History of jaundice?	☐	☐
C. Recent change in appetite?	☐	☐
D. Blood per rectum?	☐	☐
E. Frequent heartburn or indigestion?	☐	☐

	YES	NO
GU:		
A. Frequent bladder infections?	☐	☐
B. Frequent nighttime urination?	☐	☐
C. Incontinence?	☐	☐
MS:		
A. Joint pain requiring medicine?	☐	☐
B. Calf or leg pain with walking?	☐	☐
C. Arthritis?	☐	☐
Skin:		
A. Rashes?	☐	☐
B. Skin Cancers?	☐	☐
C. Other major skin problems?	☐	☐
Neuro:		
A. TIA's or minor stroke?	☐	☐
B. Recent numbness or weakness?	☐	☐
C. History of seizures?	☐	☐
Psych:		
A. Depression?	☐	☐
B. Anxiety?	☐	☐
C. Other psychiatric problems?	☐	☐
Endocrine:		
A. History of high or low blood sugar?	☐	☐
B. Thyroid problems?	☐	☐
Heme/Lymph:		
A. Bleeding tendencies/bruising, or frequent nose bleeds?	☐	☐
B. Any history of anemia?	☐	☐
C. Do you have sickle cell disease?	☐	☐

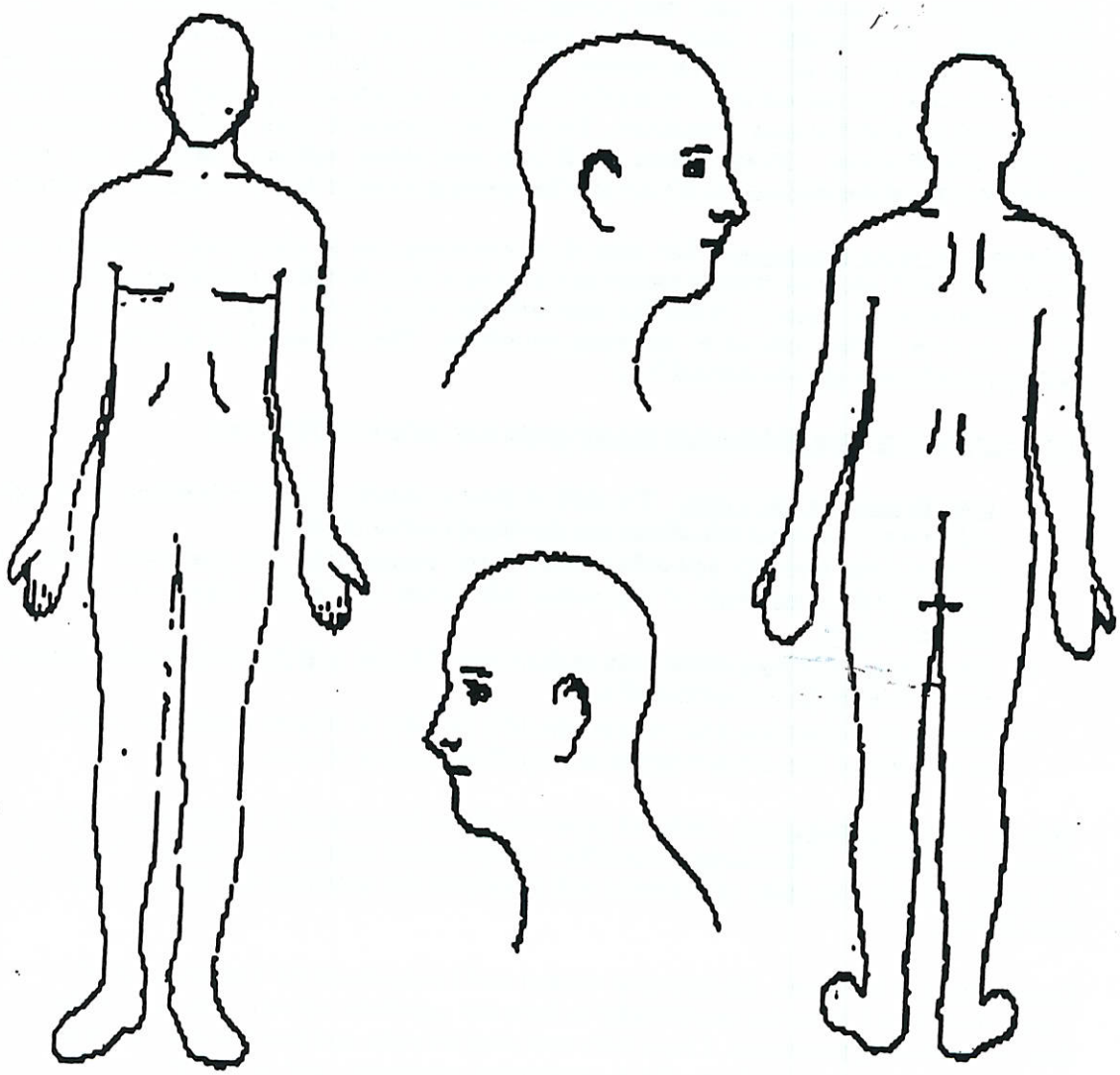
Please explain any Yes answers_____

_____

Signed_____ **Date**_____

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES



Name_____ Date_____

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Brian S. Haschets, D.C.

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: Dr Haschets will use his hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. Please inform me if your past history indicates anything that makes you susceptible to the aforementioned or if your have had previous spinal problems or heart/artery disease.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics*. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: **I have read this informed consent and I understand the unusual risks of my case. I understand that I have the opportunity to have any questions answered to my satisfaction at any time before starting treatment. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.**

Printed Name	Signature	Date

WITNESS:

Printed Name	Signature	Date